PHILOSOPHY OF SEX OFFENDER TREATMENT

1. Sex offending cannot be cured and at best, can only be controlled.

No known treatment is 100% effective for stopping sex offending. Offenders do recidivate. Treatment is to be stressed as lifelong. Completion of a treatment program does not cure sexual deviance. Long-term aftercare is a necessary aspect of community safety and the offender's well-being.

2. The focus of sex offender treatment is on the offender accepting responsibility for their offense, cycle of abuse, and all facets of their life.

For an offender, acknowledging that they committed the offense or simply saying "I did it" cannot be considered sufficient by itself. It is critical to explore and have the offender acknowledge the precursors to their offense, the cycle of distorted and deviant sexual thoughts, acknowledge deviant sexuality, acknowledge risk factors for reoffending such as grooming and control issues, as well as any other facets of the offense and their life dysfunction. Progress is also shown by the offender acknowledging the positive aspects of their life and gains made in therapy as shown by increased empathy, enhanced self-esteem, beneficial problem solving, and any other adaptive coping and social skills taught within the therapeutic structure.

3. Treatment Providers are victim advocates and not offender advocates.

The motto of all sex offender treatment providers is "No More Victims". As such, all decisions in therapy should be based on preventing further abuse and enhancing community safety. The strategies should be aimed at ensuring the offender can adapt in their life going forward.

4. Sex offender treatment is a cognitive-behavioral approach.

A cognitive-behavioral approach for sex offender treatment includes a relapse prevention focus, strong external collaboration with supervision, and medication (as indicated). A cognitive approach addresses dysfunctional core beliefs as well as current thoughts that promote maladaptive behavior. Relapse prevention is a self-control program that provides the offender with a variety of cognitive, behavioral, and social skill training tools for assuming responsibility for their behavior. Essentially, a focus of relapse prevention is learning to identify the factors that increase the risk of sexual offending and developing adaptive coping skills for minimizing or eliminating those risks. This includes identifying and escaping lapses to exit from the buildup phase of the deviant cycle before victimization.

5. Deviant sexual acting out is patterned, repetitive, and predatory.

Deviant sexual abuse has a focus on control and often seeks to compensate for other life deficits. Deviant sexual abuse is secretive and violates boundaries. It is illegal and is devastating to victims. Sexual offending is a choice. It is not a direct consequence of their abuse or any other feature of the offender's developmental makeup.

6. Community Support Groups are not an appropriate treatment.

Community support groups should not be used instead of sex offender specific treatment by a mental health professional.

7. There is no such thing as "impulse rape".

Nothing "just happens". There is a process of sex offending that is marked by a deviant cycle. Acting out of any sexual abuse has a definable build-up phase that is comprised of deviant sexual arousal, deviant cognitions, decreased empathy, a negative emotional state, and an unwillingness to use other adaptive coping skills and outlets. Other issues, such as low self-esteem, distortions about relationships, any unresolved family of origin issues, alcohol and drug abuse, childhood abuse, and similar are precursors

to the acting out behavior. The offender is "choosing" to offend regardless of their background and other contributing factors. The offender should be held 100% accountable for their crime.

8. The truth is not always apparent.

The truth is more accurately shown by behavior and thoughts that occur over time and can be verified by others. Denial is always present and multifaceted. Denial reveals shame and dishonesty; however, saying "I did do it" doesn't mean there are no other forms of denial.

9. Honest is a must in sex offender treatment.

As the saying goes, "You are only as sick as your secrets". Offenders who are in denial of their offense may benefit from an intensive period of confrontation regarding their denial. The use of objective testing may assist in the confrontation. Regardless, convicted offenders who deny should be considered high risk and eventually returned to the court authorities if denial persists beyond a reasonable limit. Sex offender treatment is designed for identified abusers who acknowledge their identity as sex offenders.

10. Treatment and therapeutic gains largely occur in stages.

Treatment should occur over an extended period. It takes considerable effort by the offender to define, understand, and control the offense behaviors. Long-term control of deviant fantasies and arousal is essential.

11. Offenders are master manipulators.

As treatment providers, we need to ensure that the offender is gaining the information necessary in treatment and not attempting to "act normal" or parrot back to you what he or she thinks you want to hear. Colluding with the offender can be minimized by using a team approach that involves human services, legal, supervisory, and community support persons.

12. Lessened risk is not necessarily inferred by progress in treatment.

Sex offender treatment providers must recognize that offenders are dishonest in many respects, with themselves and you, no matter how open they are with admitting their offense. Denial, justification, intellectualizing, and minimization are the hallmark qualities of an offender. You and the offender must always be on guard about access to potential victims and re-entry into the deviant cycle.

13. Most offenders have multiple paraphilias.

Many offenders who offend within the family boundaries will also offend outside of the family and vice versa. Having offended is a clear sign that one may do it again, albeit in a different way (e.g., exhibitionism) or the victim's gender or age. Access to potential victims must be carefully controlled. We must assess for other paraphilias.

14. Offenders have more similarities than differences when it comes to frequency and victims.

Offenders may be defined in many ways, e.g., incest offenders, pedophiles, exhibitionists, statutory rapists, serial rapists, and so on. However, the bottom line is that sex offenders act out within a cycle of deviancy and choose to violate the boundaries of other human beings. Since denial from the offender and the uncertainty about the treatment provider's ability to know if the offender is being honest (especially early in treatment), a conservative approach that benefits community safety is best when determining risk and treatment planning. With time and progress in treatment, as well as external verification of treatment progress (e.g., objective testing and reports from community support persons), treatment can be better defined. Sex offender treatment groups include all types of offenders.

15. Offenders do not fit stereotypical profiles.

The "trench coat" man or the "popsicle man" is not the average sex offender. Sex offending is pervasive and happens within all socioeconomic, ethnic, racial, and religious classes.

16. Many offenders are also victims.

Victim issues can be a component of treatment but only after the client shows responsibility and management of their abusive behavior.

There are definitive differences in the treatment of sex offenders in other clinical populations.

- Offenders are legally mandated to attend treatment. Sex offender treatment is linked to the legal system.
- A group approach is the best modality for the treatment of an offender. Good sex offender programs are group-oriented, emphasize offender responsibility, recognize the serious nature of risk involved, have a clearly defined means of assessing treatment progress, have a graduated treatment protocol, and emphasize communication with other involved professionals.
- Sex offender treatment is often directive and has definitive expectations for our clients. We set treatment goals that are contrary to the offender's wishes.
- Sex offender treatment is often confrontational.
- Work with sex offenders is prohibitive, e.g., offenders are restricted on whom they can see, where they can work and live, where they can go, etc.
- Offenders often have denial of the problem. It is imperative to get verification of the offender's behavior through the use of objective testing. Providers should doubt any self-report from the offender, especially in the early phase of treatment.
- Sex offender treatment providers place a high value on the rights and needs of others before the rights and needs of the offender. **Providers are victim and community safety advocates.**
- Sex offender treatment providers require waivers of confidentiality to facilitate community supervision and communication among involved professionals.

In general, offenders:

- will initially oppose treatment efforts. Offenders are not going to like limits. Initial motivation varies and must be cultivated.
- have an initial poor recognition of problems. Initial insight is often limited and distorted.
- act out in many ways that harm others.
- are initially dishonest to providers and themselves.
- hold secrets and hide their true selves from providers.
- will blame others for their problems and see their victimization in terms of their own needs," I was only trying to reach out to her".
- will do anything to avoid scrutiny or involvement in their life. They will try to become the best client to avoid dealing with their problems.

17. As treatment providers, we are part of a bigger team than our own office or staff.

Per statute, sex offender treatment is defined as supervision and therapy. The picture is even bigger when you frame treatment as a public health or community safety issue. Human services, legal staff, community supervisors, therapists, medical staff, supportive friends or family members, ministers, and similar persons should be included as a part of the team approach. When we think we can do it all for the offender and make a judgment of risk without consultation and appraisal, then we are likely increasing, rather than decreasing, community risk.

18. It takes specialized skills to monitor a sex offender in the community.

It is important to develop a wide continuum of strategies that will assist the community supervisor in monitoring the offender, as well as increasing protective factors that will aid in the offender's adjustment in the community. There are terms and procedures that providers must learn to converse within the sex offender field. These terms include approaches used in clinical treatment, as well as terms and procedures used by DCS, the legal system, and community supervisors.

19. Issues of reunification and victim-related issues require a careful decision process.

Reducing further victimization is a primary goal of offender treatment and any victim contact process. Adequate safeguards to promote the emotional and physical protection of the victim(s), and other vulnerable children or adults, is a necessity at all stages of reunification. Any recommendations regarding reunification must be victim-focused,

20. Sex offender treatment providers need to know their vulnerabilities.

Providers need personal boundaries in dealing with offenders and need to know any biases in working with this population. Providers need to acknowledge that working with offenders may not be the best thing for us concerning our history (e.g., past abuse). If boundaries blur between therapist and offender, then we lose the therapeutic objectivity we need to be effective counselors. A personal relationship with abusers is not condoned by the board. Working with offenders requires firm therapeutic boundaries. We must be able to confront and direct offenders into adaptive ways of coping with their deviancy. Equally, we must be able to maintain a working alliance with the offender. It is oftentimes a difficult connection to maintain as we equally withhold trust, and respect without colluding, and encourage our clients.

21. If you are not competent, you should not be a sex offender treatment provider.

Providers have a competency shown by training and experience. Providers must be willing to seek out help and clarification from peers or consult with clinical members of the Tennessee Sex Offender Treatment Board.

22. Providers specifically abide by the ethical guidelines of ATSA.

The TSOTB has adopted the guidelines of the Association for the Treatment and Prevention of Sexual Abuse as well as all state and professional practice ethical guidelines that promote the mental health treatment of individuals. We encourage professionals to always be cognizant of their professional limitations and boundaries.

23. Vicarious trauma and burnout are features of sex offender treatment work.

Sometimes the abuse stories that we hear impact providers emotionally. Working with offenders is stressful. If providers are not occasionally emotionally stressed by what is heard or by the work done in sex offender therapy, then perhaps the provider is far too distant from the issues that need therapeutic attention. However, it is important for providers to rationally detach from the job when they leave the workplace. Therapist support and ongoing plans for dealing with the distressing aspects of our work are necessary for maintaining mental health.

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